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COMPREHENSIVE HIV SERVICES PLAN
2000 - 2001

Executive Summary

The FY 2000-2001 Comprehensive HIV Services Plan developed for the Orange County Eligible Metropolitan Area (EMA) is the result of an open community planning process. Participation in the process was broad-based and occurred at many levels and through many different modalities. This plan represents the efforts of a large number of people working together to improve the quantity and quality of medical care and support services available to people living with HIV. Input from consumers, service providers, HIV Planning Council members, committee members, members of the affected community, and grantee and HIV Planning Council staff has been crucial in shaping the major elements of the Plan.

Development of the Comprehensive HIV Services Plan was coordinated with the priority setting and resource allocation activities of the Council. In December 1998, a needs assessment task force was established. Included on this task force were consumers, providers, staff, Planning Council members and experts in survey development and research design. This committee developed a work plan that included the collection of needs assessment data based on an epidemiologic profile of the EMA and a client survey. Since key informant interviews and focus groups had been conducted the previous year, it was decided to rely on that data rather than to repeat those processes this year. With the help and participation of hundreds of people, this information was collected over a period of several months in the Spring of 1998.

In April 1999, the HIV Planning Council held a strategic planning retreat. At the retreat, participants reviewed the Planning Council's vision, values, and goals and objectives developed the prior year. There was consensus that the vision and value statements were still valid. There was a presentation on the planning process and another on the current status of our progress in meeting the goals and objectives established last year.

The priority setting and resource allocation processes used by the Planning Council afforded another opportunity for input and direction from the community. An enormous amount of community and staff time went into completing the work in support of the needs assessment and priority setting/resource allocation processes. In addition, several Planning Council Committees (e.g. Housing and Public Policy) were instrumental in providing input into the development of the Plan.

The plan is intended to be a dynamic document that will be revised and updated annually. For this round, interested individuals and key Planning Council members were offered the opportunity to review and comment on chapters of the plan as they were developed. All comments and suggestions were carefully considered, and the plan was modified accordingly. In addition, copies of the entire plan were distributed to all Planning Council members for approval.

This plan represents a good faith effort by a large group of interested community members to put together a coherent body of knowledge about the need for, and delivery of, HIV services in the EMA, to develop a number of goals and objectives designed to enhance the continuum of care, and to improve the quality and efficiency of both the service delivery system and the planning process. The following is a brief summary of some of the highlights of each chapter.

Chapter 1 provides an historical overview of Orange County's response to the HIV/AIDS epidemic. Key areas discussed include:

- Surveillance
- Education and prevention
- Testing and counseling
- Medical care and medications
- HIV-related supportive services
- Laboratory services
- Collaborative planning
- Benchmarks in the history of HIV disease in Orange County

Chapter 2 provides a description of the epidemiology of AIDS in Orange County. Key points include:

- There have been 5,149 cases of AIDS reported in Orange County as of March 31, 1998.
- It is estimated that 6,700 persons are currently living with HIV/AIDS in this EMA.
- There is a trend towards an increasing proportion of people of color living with AIDS. AIDS prevalence increased 11% among Latinos, 8% among African-Americans, and 4% among A/PIs between 1997 and 1998 compared to 3% among Whites.
- There have been changes in the risk profile of persons living with AIDS. Although men who have sex with men account for the largest number of prevalent cases of AIDS (73%), the largest increase in AIDS prevalence between December 1997 and December 1998 occurred among those persons infected through heterosexual contact (11%). Pediatric cases also increased by 11%, but the total number of pediatric cases is still very small (n=20).
- During the period January to June 1998, the number of AIDS deaths (32) was 43% lower than the number of deaths in the same period of 1997 (56). The decrease in AIDS deaths reflects

both the leveling of new case reports and the improved survival of persons living with AIDS. This increased survival reflects recent improvements in medical care.

Chapter 3 provides a description of the needs assessment process used in 1999 and presents a discussion of the results. Key points include:

- The 1999 needs assessment consisted of a client survey, review of information from focus groups/key informant interviews conducted in 1998, and an analysis of the California Statewide Coordinated Statement of Need.

- The results from both the client survey and focus groups/key informant interviews showed that medical care was the highest priority service category.

- Based on weighted values, the top five service priorities are (1) Medical Care, (2) HIV/AIDS Medications, (3) Housing Assistance/Rent & Utilities, (4) Food Bank/Food Vouchers, and (5) Mental Health Therapy

- Services most used by respondents are Medical Care (used by 86%), AIDS medications (55%), Dental Care (51%), Case Management (46%), and Nutritional Counseling (45%).

- The number one unmet need identified by respondents was Housing Assistance/Rent & Utilities. Dental Care, Food Bank/Food Vouchers, Benefits Counseling, Complementary Therapies, and Legal Services also were frequently mentioned as services that clients needed but couldn't get.

- In both the client survey and the focus group/key informant interviews, the barrier to care most frequently mentioned was lack of information about services available; eligibility for services; and how to obtain the services.

- The needs assessment results for Orange County showed strong consistency with those found in California's Statewide Coordinated Statement of Need.

Chapter 4 provides an overview of the availability of, and the need for, housing for persons living with HIV in Orange County. Key points include:

- In Orange County, the problem of homelessness among those living with HIV is exacerbated by the high cost of rental housing and the fact that there are more low-income renters than low-cost housing units available.

- In January 1999, a comprehensive housing study was begun by the City of Santa Ana with the help of consultants from AIDS Housing of Washington. When complete, the study will provide information on the existing housing resources, unmet needs for housing and related support services, and strategies for meeting those needs. Some of the key results from the needs assessment done as part of that study are presented here:

- 24% of all respondents had been homeless at some point in their lives;
- 13% had been homeless during the past three years;
- 4% had been homeless three or more times;
- Women and African-Americans are disproportionately affected by homelessness;
- 39% of respondents had moved since learning of their HIV status, most frequently because of inability to pay the rent;
- 12% of all respondents were on the streets, in shelters, in residential hotels/motels, or "crashing for free" when they completed the survey;
- 73% indicated that they would have to move if their rent or mortgage payment increased by $50;
- 78% or respondents answering the questions paid more than 30% of their income for rent and 51% paid more than 50% of their income on rent.

Chapter 5 describes the continuum of health care and supportive services available for PLWHs in Orange County. Key points include:

- Recent changes in treatment regimens have caused improvements in the medical status, life expectancy, and quality of life for PLWHs. These improvements have affected the need for specific HIV-related services.
- Service categories that have emerged as relatively more important are substance-abuse treatment, assistance with re-entry to the work force, and housing.

Chapter 6 presents an overview of the different funding streams that are being used in Orange County to support the continuum of HIV prevention, health care, and support services. Key points include:

- For calendar year 1997, expenditures on medical and health care-related HIV services, accounted for approximately $9.2 million of the approximately $13.8 million in federal, state, and local HIV funds in the EMA.
- The four largest providers (AIDS Services Foundation, the Health Care Agency: Public Health, the Health Care Agency: Behavioral Health, and the University of California Irvine Medical Center) accounted for 86% of the total expenditures.

Chapter 7 discusses coordination and linkages among the HIV Planning Council, other planning bodies, federal and state-funded HIV-related programs, and Orange County service providers. Key points include:

- Coordination between Ryan White Title I, Title II, and Housing Opportunities for Persons with AIDS (HOPWA) is built into the structure of the Planning Council. There is one priority setting and resource allocation process used for all three funding streams.

- Coordination with AIDS Education and Training Centers (AETC) occurs through a member of the Planning Council who is also staff of the local AETC. Coordination with AETC is demonstrated by the collaborative effort involved in presenting the annual *AIDS on the Front Line Conference.*

- There are several indicators of provider interagency coordination, including the establishment of the HIV Wellness Collaborative of Orange County, the out-stationing of staff among agencies, the work of the Comprehensive Services Delivery Group, and the formation of the Total Opportunities for Underserved Communities Affected by HIV (TOUCH) collaborative.

Chapter 8 discusses client participation and advocacy in the EMA. Key points include:

- The HIV Client Advocacy Committee (HCAC) plays an important role in this EMA. Responsibilities of the committee include identifying HIV-positive individuals to fill leadership roles on the Planning Council, providing trainings for these individuals, developing the advocacy skills of PLWHs, and advising the Planning Council on service needs of PLWHs.

- Members of HCAC have historically participated in a variety of advocacy activities including visits to elected officials, letter writing, and membership in advocacy organizations.

- There is close coordination between the Planning Council, its Public Policy Committee, and HCAC.

Chapter 9 presents a discussion of some of the major issues that may impact the planning and delivery of services locally. Key points include:

- Due to the large size of the County and the lack of adequate public transportation, geographic access to services is a significant issue.

- Back-to-work issues are of great importance to PLWHs. Given the uncertainty and instability of the health status of many PLWHs, there is a need to ease transition back into the labor force by allowing retention of Medicaid and Medicare benefits for a limited time after re-entry.

- Although AIDS is a reportable condition in California, HIV infection is not. The Assembly of the California legislature has approved a bill providing for HIV surveillance, as of August 1999; however, it is uncertain as to whether or not it will become law. HIV surveillance data is needed to monitor local changes in epidemiology and provide better information for planning.

- Changes in technology, including new treatments, advances in viral load testing, the development of a rapid test for detecting antibodies to HIV, and work being done to develop a vaccine have impacted the care, treatment, and service needs of PLWHs.

- Local changes in populations affected by the disease, including increases in the number of clients with multiple diagnoses, have created a need for improved access to local substance abuse and mental health programs on the part of AIDS services organizations.

- Orange County has been very successful in implementing programs aimed at decreasing perinatal transmission.

Chapter 10 discusses the shared values of the members of the Planning Council and the Council's vision for the future. Key points include:

- At the April 14, 1999 Planning Council retreat, the Council decided by consensus that the Shared Values Statement and the Vision Statement developed in 1998 were still valid.

- The Shared Values Statement addresses values regarding the provision of information and services, the planning process, communication, and the service-delivery system. It also includes a commitment to maximizing the community well-being, following the Rules of Respectful Engagement, and providing accountability on all levels.

- The Vision Statement: *Through partnerships that reflect the combined efforts of the Orange County HIV Planning Council, affected communities, service providers, philanthropists, and public health professionals, there is an accessible continuum of HIV prevention and care services that fosters individual self-sufficiency and results in no new HIV transmission.*

Chapter 11 presents an overview of the planning and implementation processes. Key points include:

- The Planning Council ranked service categories in priority order using a deliberative and consensus-driven process that took into consideration: vision, values, epidemiologic data, needs assessment data, decision criteria, expenditures and service utilization data from FY 1998-99 and the Planning Council's service-related goals and objectives.

- A recommended funding allocation scenario was developed based on FY99 allocations, expected future funding levels, current spending patterns, estimates of current unmet need, and anticipated future need. Instructions to the grantee were also developed.

Chapter 12 describes the goals and objectives related to the provision of services, changes in the service-delivery system and improvements in the planning process. Progress over the past year in meeting these goals is also discussed. Key goals include:

- Goal 1: Increase the length and improve the quality of life for those persons living with HIV (PLWHs) through the provision of medical care and support services.

- Goal 2: Develop and implement strategies for improving linkages between providers.

- Goal 3: Develop and implement strategies to strengthen the linkages between HIV prevention and services.

- Goal 4: Facilitate efficient service delivery and increased access to Ryan White and HOPWA-funded services for clients.
- Goal 5: Improve the flexibility and quality of the case management system in the EMA.

- Goal 6: Increase client self-sufficiency.

- Goal 7: Improve the efficiency of the Planning Council in performing its mandated responsibilities.

- Goal 8: Improve measurement of impact of programs funded by the Ryan White CARE Act.

- Goal 9: Improve the availability of housing and related support services for PLWHs.

- Goal 10: Plan for different funding scenarios that might result from the year 2000 reauthorization of the Ryan White CARE Act.

Chapter 13 discusses the monitoring and evaluation processes and procedures utilized in the EMA. Key areas addressed include:

- Evaluation of the grantee.

- System-wide oversight, including service prioritization, resource allocation, performance indicators and outcome and cost-effectiveness measures.

- Programmatic oversight, including fiscal accountability, contract compliance, quality improvement, and standards of care.